Sustainable Development Goal 3 Global Action Plan (GAP) Outline and Accelerator Papers

United States Comments – July 2, 2019

General Comments:

- We very much appreciate this process of opening up the SDG3 GAP for comment. While the Action Plan is meant to be carried forward by 12 organizations, its implications are far-reaching, thus we would encourage continued opportunity for updates and robust exchange with all stakeholders.

- This document is presented as an inter-agency plan defining concrete, collective actions of 12 organizations to support countries in accelerating progress toward the health-related SDG targets. As we noted during the 72nd World Health Assembly, this is not a Member State-agreed document; using a title other than "global action plan" may alleviate confusion, as the World Health Assembly often does negotiate or approve documents so titled. Referring to this document as a "Country-level Global Collaboration Plan" or something similar may both alleviate confusion as to its status as an internal, rather than Member State document, while underscoring and framing collaboration, coordination and engagement at country level as a driving purpose.

- We welcome the general effort for these 12 organizations to coordinate more closely, especially in areas related to coordinating on operations in-county including on program design, implementation, and reporting when appropriate and possible. More detail on plans to increase operational efficiencies would be appreciated.

- The GAP should address areas of convergence and joint action to address opportunities to improve health, but it goes well beyond that, and introduces some concepts that Member States have not endorsed in governance documents or negotiations including "commercial and structural determinants of health." The GAP and its seven "Accelerators" contain specific, prescriptive policy and regulatory recommendations, rather than leaving these decisions to the appropriate decision-makers: national governments.

- Further, policy recommendations are included without adequate grounding or evidence to demonstrate that the recommendations would lead to improved public health outcomes.

- There's an extreme imbalance in how civil society and private sector are referenced in the GAP and its accelerators. We are concerned that characterizations of the private sector as "health harming" do not advance the discussion and provide little means for joint action or dialogue. The executive summary begins with a section titled: "Advancing the joint commitment to work together", yet the document itself and its Accelerators lay out a foundation which could be seen as discrediting and isolating the private sector from meaningful engagement with regulators and public health officials. Both the GAP and its accelerators should include more references to the positive role the private sector can play in advancing the GAPs objectives including through public-private partnerships.

- It would be helpful to understand how the SDG GAP links to other coordination frameworks, including strategies to accelerate progress on the SDGs through many of the same partners. How will this new process enhance existing efforts?

- Pg. 8 of the rollout plan mentions "expansion of country engagement" and "collective country actions". It is not clear which countries are already engaged/committed, which countries are being prioritized (and why/how), and what is meant by "collective country actions". Priority countries are mentioned in some of the individual Accelerator Frames but not all. Further detail on how this will be rolled out in countries would help to clarify and enhance the plan.

- Across the various accelerator frame documents, there is mention of plans to create tools or exchange platforms. In some of these areas, tools already exist, thus we strongly suggest a focus on advancing or scaling or what has been initiated as well as a commitment to efficiency as a top priority for the GAP.

- We are pleased the GAP acknowledges the significance of environmental risk factors for public health. WHO estimates that 12.6 million deaths each year are attributable to unhealthy environments, including about seven million deaths from exposure to air pollution.

- As expressed by a number of participants in the WHO-hosted side session on the GAP on the margins of the May 2019 World Health Assembly, the GAP was developed by the IOs through an opaque process without input from Member States or other stakeholders.

This is potentially appropriate if the plan is essentially an internal document related to operationalizing policy and technical agreements made by each of the participating organizations in service to SDG 3.

- The Seven Accelerators are described as providing "specific focus for potential joint action by the 12 signatory agencies". Given the central focus on the seven accelerators, substantive concerns regarding content in these documents should be addressed and documents revised prior to the UNGA. Further, Member States and other stakeholders should be allowed another opportunity for consultation after Section 4.2 is finalized.

- For the United States, the value in this exercise is in more effective and coordinated UN system support to countries at country level, not in the roll out of another global plan. With that in mind, we hope that WHO and other participating agencies will be driven by that same focus and not by calendars and side events. If more time is needed, and based on the current state of some of the document, we think it might be, we do not believe this plan should go to UNGA in the fall for any kind of roll out or endorsement.

Accelerator 1: Sustainable Financing

- There is currently a $134 billion annual investment gap for the health SDGs in low and middle income countries (roughly the size of all official development assistance combined) and by 2030, the estimated gap is projected to be $371 billion. Successfully attracting private capital to support development goals will be crucial to fill the gap, yet the entire paper has only one bullet point regarding the private sector. The accelerator needs to make private sector investment and blended finance a core part of its strategy if it hopes to play a role in achieving SDG3.

- We support the goal of better coordination of development partners and alignment of assistance to national health priorities. Accelerator 1 initially focuses on support for "a country led, demand driven and evidence-informed agenda on sustainable" but quickly shifts toward prescriptive recommendations such as "global advocacy" for "public health-related taxes". Tax policy decisions are best left to national governments and should be considered in the context of SDG 8: Decent Work and Economic Growth. Further, "tax avoidance" is a complex issue and unrelated to health financing. Recommend removing the reference from this accelerator.

- We cannot assume that the net-benefits to health of taxes are positive. Each country should be encouraged to do an assessment that considers its specific market and socio-economic conditions. In addition, beyond the health benefits from best buys like tobacco and alcohol taxes, the "double-win" is not realized unless Governments actually direct revenue generated to health system strengthening and we would like to see guidance in this area strengthened.

Accelerator 2: Primary healthcare

- We applaud the strong focus in this accelerator on primary health care through empowering people, families and communities and while we urge a thorough scrub of the document to ensure that language used is consistent with WHO and other agency policies and resolutions, we believe this accelerator is well-positioned to have a significant impact at country level if fully implemented.

- This Accelerator could further emphasize the need for *quality* primary health care to maximize value for the resources invested. This should start with measuring outcomes and costs at the patient level longitudinally across a care pathway and across care settings (community, primary health center, etc.), using this data to adapt and deliver better care, and potentially rewarding providers who are able to achieve better results.

Accelerator 3: Community and civil society engagement

- This is another essential accelerator for the plan to have the impact and success we all hope for and need to see. As noted, the SDGs recognize the imperative of multi-stakeholder decision-making, that neither governments nor the UN alone have all the answers and capacities needed to reach our shared goals. The accelerator references inclusive, participatory decision-making (16.7), multi-stakeholder partnership (17.16) and public, public-private and civil society partnerships (17.17). However, the paper solely then focuses on a part of the stakeholders concerned, communities and civil society.

- The private sector, in all its diversity and contributions also needs to be brought into the discussion as they will contribute to and benefit from the engagements leading to shared public health goals, and then can be more effectively held to account if they do not deliver.

- Partnerships should be looked at first from the perspective of the national or country-level health priority that needs to be addressed, an analysis of the gaps preventing achievement of that goal, and then what partners are available to work together to achieve the goal.

- Strong protections against conflict of interest, promoting transparency in any partnership, and assuring full commitment to the health goal in question need to be in place, but this accelerator needs to be further developed to realize its full potential for health.
- Within communities, it is noteworthy that Faith Based Organizations provide 40-70% of health care delivery in many developing countries, especially in parts of Sub-Saharan Africa. They enjoy community trust, have access to individuals and family information that may not be shared with others (trust), are most often there for the long-term, and their work is often low-cost but high impact. Their inclusion is an essential part of this document and needs further mention.

- This accelerator is fairly comprehensive in scope, however, it only references youth as beneficiaries, not as partners in the CSO space. It is critical to [HYPERLINK "https://www.youthpower.org/resources?search_api_fulltext=Meaningful+Youth+Engagement&sort_by=search_api_relevance&sort_order=DESC" \h], especially when they are the majority of the population in most of the countries in which WHO works. Including youth voices and perspectives would make the Accelerator more relevant and useful in the long run. This should also be measured, that is, include indicators related to youth participation and meaningful engagement in the process, as well as for country progress.

Accelerator 4: Health Risk Factors

- On multiple negotiated documents and over many years Member States have used the terms social, economic, and environmental determinants of health. These documents introduce a different paradigm (environmental, commercial, and structural) of health determinants) without any clear explanation or rationale, which are not consensus terms and do not enjoy a common understanding among Member States. We strongly oppose this framing and the specific reference to "commercial and structural determinants of health" The GAP should build on the common understanding of

Member States, rather than advancing alternative concepts not endorsed by Member States through the relevant governance processes.

- In short, as drafted, this accelerator is a recipe for rejection of this whole plan at country level and the extreme policy views being shown in this draft text put at risk the very goals of health promotion and ensuring that no one is left behind, both of which we strongly support.

- The United States reiterates its call for participating agencies to do a full scrub of this accelerator paper to ensure that all language is taken from agreed sources, particularly where they involve sensitive or controversial topics, to ensure maximum buy-in by countries and by relevant stakeholders to secure the needed changes and the hoped for improved health outcomes.
- With so many different types of determinants, the text actually introduces mixed messages around action, and certainly is well beyond the mandates of the 12 UN agencies involved.

- The document also references "pervasive lobbying," "industry interference in policymaking", and "health harming practices", setting an adversarial tone before concluding that public-private partnerships are needed. The section is incongruous and should be revised to remove the unnecessarily adversarial and biased categorization of private sector activities.

- In addition, while not diminishing the changes that need to happen from some industry actors to achieve the SDGs, this paper completely ignores the positive impacts that the private sector has, large and small on health outcomes from their roles as employers and health insurance providers in many countries, to the products they produce from life-saving medicines to the sports equipment that gets us out of our homes and offices and moving around.

- It would be a missed opportunity if this Action Plan did not include efforts to more effectively engage with the whole range of non-State actors. We recommend that this Accelerator tailor its framing to clarify that countries should work with the private sector to define common interests within organizational priorities with national policies. Regarding conflict of interest provisions (p.5), IOs should not create additional barriers to engagement for any sector beyond tobacco and arms for exclusion. There should also be clearer links shown across accelerators and in particular between this one and that for community and civil society engagement.

- Under "Multi-sectoral governance" (p.5), IOs should not dictate to collaborating countries which stakeholders should be included or excluded from participating in various initiatives. Members should always be conscious of their international trade obligations when considering regulatory changes.

- This accelerator also contains broad generalizations without justification or evidence (e.g. that burning of fossil fuels and sugar sweetened beverages are a "drag on the economy"). This should be removed.

- We encourage the plan drafters to consider additional joint actions to be taken to address environmental determinates of health and to specifically address health risks from air pollution. For example, the coalition could collaborate with the UN Environment Programme to address health risks from air pollution. One potential "area of joint action by GHOs to support countries in line with national priorities" is to encourage regional cooperation to address air quality concerns and the sharing of best practices on strategies to address air pollution.

- We would like to see more reference to disability in this section. Disability is a significant risk factor for poor health. For example, today, over one billion people need at least one form of assistive technology, such as wheelchairs, eyeglasses, hearing aids, prosthetics, and personal assistance devices. By 2030, this number is expected to grow to more than two billion people. Over 90% of this population does not have access to the AT they need, creating significant consequences for individuals, their families, and society at large. This lack of access can limit educational attainment, care-seeking behaviors, and income generation to support healthy habits, to name just a few.

Accelerator 5: [HYPERLINK "https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-5.pdf?sfvrsn=edc2788e_2" \h][HYPERLINK "https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-5.pdf?sfvrsn=edc2788e_2"]

- No mention of intellectual property was made in Accelerator Paper 5: Research and Development, Innovation and Access. Was IP not mentioned because no contribution was made regarding IP? If submissions were made regarding IP, it would be helpful to understand why a discussion of IP was excluded.

- Consider including support for complementary methodologies in research and development, such as design thinking or human-centered design, to contribute to better

health outcomes. Through its people-centered and iterative approach, design thinking is increasingly recognized as an approach that can improve uptake and adherence; strengthen strategy and implementation planning; introduce new capabilities and collaboration models; and boost buy-in and ownership across all levels of health systems.

- Support for innovations needs to be equally focused on scale. Global health innovations in high-income countries often reach their coverage targets within five years. In low- and middle- income countries, it can take decades, if at all, to reach coverage targets. While not an apples-to-apples comparison, increased focus on strategic introduction and scale planning and market shaping can help increase the likelihood of successful scale-up for global health innovations in LMICs.

- We note that WHO prequalification can be a critical step for introduction of tools in low and middle income countries, but that these processes could benefit from more strategic prioritization.

- In Goal 4, we appreciate the note that implementation science has not research enough attention and that this creates a barrier to scale. Nonetheless, there should also be clear efforts to disseminate evidence. The Global Observatory on Health R&D simply existing is insufficient if it is underutilized. The group should prioritize dissemination through various media and at the country and regional level through WHO offices.

- In Action 5, WHO should seek broader inclusion in curating their repository of 'evidence-based innovations that could be scaled. Research funders should be included in the key stakeholder groups from the onset because most such technologies will have fallen within their research portfolios at some point.

Accelerator 6: [HYPERLINK "https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-7.pdf?sfvrsn=30405e53_4" \h]

- Natural disasters role in creating vulnerable and fragile contexts is largely left out of this document. It should be considered as natural disasters grow in number and strength due to climate change and cause a large number of humanitarian crises that require an emergency humanitarian response. There should be a greater focus on disaster risk reduction, early warning systems, and surveillance. There can be better attention drawn to the need for private sector partnerships to increase health systems' resilience.

- The accelerator does not include the voice or representation of health program beneficiaries, that is, conflict affected/vulnerable communities. To make the design and implementation of the services more effective and appropriate to the community needs, the accelerator should include community representation in all components of the work and in all phases.

- The accelerator should address 1) sexual and gender-based violence (SGBV) and the importance of including screening and treatment services within health care facilities, outreach services, as well as links to mental health services; 2) the continuum of care needed for beneficiaries and how to develop/facilitate the continuum for people who are on moving from place to place due to conflict or natural disasters; 3) the need to train and support beneficiaries with providing more self-care; including first aid, ORS, emergency contraception; contraception; HIV and other chronic disease treatment, etc.

Accelerator 7: Data and Digital Health

- We are pleased to see this Accelerator frame: data will be a driver of value in the coming years and decades, multiple stakeholders will generate data of value, and bringing disparate data sources together will amplify the value.

- In order to harness the most value, the GAP partners should adopt a data vision that calls out data for public health as a common good, one that should be freely shared, and not held by any single institution.

- The GAP should also welcome additional stakeholders, such as IHME to the table in order to generate more value from analyses of existing data.